DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
DIVISION OF CUSTOMER SUPPORT

HOSPITAL INJURY REPORT

The medical provider will complete this report and forward it to the Division of Customer Support, Coordination of Benefits, Casualty Unit.

PATIENT'S NAME		PARENT'S NAME (IF CHILD)	
STREET ADDRESS	CITY	STATE	ZIP CODE
PATIENT'S IDENTIFICATION CODE (PIC)	PATIENT'S AGE	DATE OF INJURY	
NAME OF PATIENT'S INSURANCE COMPANY			
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF PATIENT'S ATTORNEY			
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF HOSPITAL	ATTENDING PHYSICIAN		
DIAGNOSIS			

AUTO ACCIDENT

LOCATION OF ACCIDENT STREET ADDRESS	CITY	STATE	ZIP CODE

Patient Was (Check One): ☐ Driver ☐ Passenger ☐ Pedestrian

NAME OF AUTOMOBILE DRIVER		TELEPHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
OWNER OF AUTOMOBILE (IF DIFFERENT FROM DRIVER)		TELEPHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF INSURANCE COMPANY OF OWNER OR DRIVER		TELEPHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

OTHER AUTOMOBILE INVOLVED

NAME OF AUTOMOBILE DRIVER		TELEPHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
OWNER OF AUTOMOBILE (IF DIFFERENT FROM DRIVER)		TELEPHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF INSURANCE COMPANY OF OWNER OR DRIVER		TELEPHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

DSHS 13-730 (11/2003)

COMPLETE OTHER SIDE

OTHER TYPE INJURY

Type of Injury (Check One): ☐ Assault ☐ Fall ☐ Job Related ☐ Other (Describe Below)

PLACE WHERE INJURY OCCURRED			TELEPHONE NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE
PERSON WHO OWNS/CONTROLS PROPERTY WHERE ACCIDENT OCCURRED			TELEPHONE NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE
NAME OF INSURANCE COMPANY			TELEPHONE NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE

Patient Was (Check One): ☐ Employee ☐ Guest ☐ Customer ☐ Other (Describe Below)

PERSON COMMITTING ALLEGED ASSAULT			TELEPHONE NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE

HOW DID INJURY OR ACCIDENT OCCUR? (USE ADDITIONAL SHEET IF NECESSARY)

SIGNATURE OF PERSON PREPARING REPORT

IF YOU HAVE QUESTIONS, CALL TOLL FREE 1-800-562-6136

MAIL THIS FORM TO:

DIVISION OF CUSTOMER SUPPORT
COB CASUALTY UNIT
PO BOX 45561
OLYMPIA WA 98504-5561